STATE OF HAWAII
STATE PROCUREMENT OFFICE

Application for Treatment Purchase of Services

Statement of Qualifications 2006

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TREATMENT PURCHASE OF SERVICES
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Application Availability

Applications are available at the State Procurement Office, and can also be downloaded from the State Procurement Office website at www.spo.hawaii.gov. Click on "Health and Human Services," and "Treatment Purchases of Services Solicitation…"

Submittal Deadline

All applications shall be postmarked by the United States Postal Service (USPS) on or before August 31, 2006, or hand delivered to the State Procurement Office no later than 4:30 p.m., Hawaii Standard Time (HST), on August 31, 2006. Applications postmarked or hand delivered after the submittal deadline shall be considered late, will not be evaluated and shall be rejected. Deliveries by private mail services such as FEDEX shall be considered hand deliveries. Dated USPS shipping labels are not considered postmarks.

Applications shall be submitted to: State Procurement Office
1151 Punchbowl Street, Room 230-A
Honolulu, Hawaii 96813

Copies

Applicant shall submit ONE original and THREE copies of the application and all supporting documents.

Documentation of Minimum Requirements

Where licensure, registration, or board certification is required, applicants must submit three copies of the credential(s). Where applicable, board certification means certification by a member board of the American Board of Medical Specialties (ABMS). If applicant is "board eligible", it shall be the applicant's responsibility to provide documentation of eligibility. The State will not make the determination of board eligibility.

Where experience is required, applicants must submit three copies of a curriculum vita highlighting the pertinent information.

Where a degree is required, applicants must submit three copies of the degree or letter from the granting institution indicating the subject matter of the degree.

If applicant is not a sole proprietor, at least one member from the applicant's organization shall meet the minimum qualifications for the service(s) applying.

If applicant is a Hawaii State licensed and/or federal certified facility or agency that is required to have staff qualifications that meet the service qualifications specified herein, applicant may submit a copy of the current license and identify the type of facility/agency applicant is operating in lieu of documentation of staff qualifications.

For informational purposes only, applicant may submit copies of additional credentials.

Evaluation of Statement of Qualifications

For each service listed, an evaluation committee shall review each applicant's statement of qualifications and supporting documents to determine whether the minimum service qualifications are met.

Placement on the Treatment List of Qualified Private Providers

If qualified, the applicant will be placed on the Treatment List of Qualified Providers.

It is the responsibility of the provider to advise/update the State Procurement Office of any changes such as changes in address, contact information, or change in qualifications.

Bases for Use of the Treatment List by Purchasing Agencies

The list may be utilized by various State agencies on an "as needed" basis pursuant to Section 103F-404, HRS, and Chapter 3-145, HAR.

State agencies may utilize the Treatment List of Qualified Private Providers to purchase services when the following three conditions occur.

1. The need for such services arises from time to time, but the need cannot be anticipated accurately on an annual or biennial basis and delaying treatment until a competitive purchase of service could be completed would render the problem worse than at the time of diagnosis or assessment.
2. The contract will be for one year or less; and
3. The contract will be for $100,000 or less.

Selection of Providers by a Purchasing Agency

When the need to purchase treatment services arises, the head of the State agency or designee shall contact a minimum of three providers from the appropriate list and select the most advantageous provider based on:

- Demonstrated competence for the type of treatment service required;
- Qualifications for the type of service required;
- Fairness and reasonableness of price, or other applicable factor; and
- Any additional criteria that the purchasing agency deems relevant to the selection.

At the time of provider selection, the State agency may require that the provider's license be unencumbered/in good standing.

Application Renewal

Qualified providers shall remain on the list for a period of two years and shall reapply biennially. The State shall not be responsible for notifying providers of any future solicitations.

Questions

Questions may be directed to Corinne Higa at (808) 587-4706, corinne.y.higa@hawaii.gov or Mara Smith (808) 587-4704, mara.smith@hawaii.gov.

Instructions

1. **Applicant Information**
   Legal Name of Business Entity. Enter the legal name of the business entity. If the applicant is an organization required to file business standing with the Dept. of Commerce and Consumer Affairs, enter the registered name.
   Doing business as (dba). If the applicant is doing business using a name other than the legal name enter it as a dba.
2. **Address**. Enter the business and mailing addresses. Post office boxes should not be used as the business address.
3. **Type of Business Entity**. Check applicant's type of business. If the applicant is incorporated, enter the state of incorporation.
4. **Contact person for matters involving this application**. Enter the name and information of the person to contact should there be questions about this application.
5. **Contact person(s) for treatment service**. Should this application meet minimum qualifications, enter the name and information of the person the state agency should contact when requiring services. Attach separate sheets if there is more than one service and contact.
6. **Geographic Area.** Check all the geographic areas applicant is willing/able to serve. If there are any exclusions to part of a geographic area, enter them in comments.
7. **General Population.** Check all populations applicant is able/willing to serve.
8. **Special Population.** As applicable, enter any special populations applicant is able to serve.
9. **Authorized Representative.** Enter name, title, phone number and authorized signature.
10. **Branch Office(s)**. As applicable, enter branch offices and addresses.
11. **Years in Business**. Enter the number of years applicant has been established in business.
12. **Number of Employees.** Enter the average number of employees over the past 3 years.
13. **Medicaid.** Indicate if applicant is a Medicaid provider.
14. **MEDQUEST**. Indicate if applicant is a MEDQUEST provider.
15. **Organization Description.** Provide a brief description of organization/business and service capability.
16. **References.** Enter names and contact information for two references.
17. **Comments (optional).** For informational purposes only, applicant may submit a separate sheet identifying the service(s) applying for and enter any comments, limitations or additional credentials/qualifications relevant to the service(s).

Service Application Pages. Complete as applicable. Note that applications are being solicited only for the services listed. When applying for a service category with checkboxes, at least one service must be checked. Applicant may submit additional sheets if needed.

STATE OF HAWAII
STATE PROCUREMENT OFFICE

Application for Treatment Purchase of Services
Statement of Qualifications

1. Applicant Information

Legal Name of Business Entity:

_____

(If applicant is an organization required to file with the Dept. of Commerce and Consumer Affairs, enter registered name.)

Doing business as (dba): (If other than stated above)

2. Address

Business (Street) Address: *(No PO Boxes)*

Mailing Address: *(for correspondence)*

3. Type of Business Entity:

- ☐ Non Profit Corporation
- ☐ For Profit Corporation
- ☐ Limited Liability Corporation (LLC)
- ☐ Partnership
- ☐ Limited Liability Partnership (LLP)
- ☐ Sole Proprietorship/Individual

State of incorporation, as applicable: _____

4. Contact person for matters involving this application.

Name: _____

Title: _____

Phone: _____

Email: _____

5. Contact person(s) for treatment list service(s). (Attach separate sheet if more than one contact.)

Name: _____

Title: _____

Phone: _____

Email: _____

6. Geographic area(s) applicant is able/willing to serve.

☐ Oahu ☐ Hawaii ☐ Maui

☐ Kauai ☐ Lanai ☐ Molokai

7. **General population(s) applicant is able/willing to serve.**

Age

☐ 0-3 ☐ 3-5 ☐ 5-10 ☐ 10-12 ☐ 12-18

☐ 18-21 ☐ 21-55 ☐ 55-59 ☐ 60+

☐ Families

8. Special Population(s) Applicant is Able to Serve:

9. I certify that all information provided in this application is correct to the best of my knowledge.

Name of Authorized Representative (type/print): _____

Title: _____ Phone Number: _____

Authorized Signature: _____ Date: _____

10. List branch office(s) and address(es), if applicable:

11. Number of years established in business _____

12. Average number of employees over the past three years: _____

13. Is your business a Medicaid provider? ☐ Yes ☐ No

14. Is your business a MEDQUEST provider? ☐ Yes ☐ No

15. Provide a brief description of the organization/business and service capability.

16. Names and business phone numbers of at least two references. The State reserves the right to contact references to inquire about the applicant's work performance.

Point of Contact	Company/Business	Telephone No.

17. Comments. (See instructions)

Applicant _____

BEHAVIOR ANALYSIS

Minimum Qualifications: ***Education:*** Masters degree in psychology or educational psychology; and
Experience/Training: 1-year behavioral assessment for developmentally disabled

List at least one employee who meets minimum qualifications for behavior analysis:

Name	Masters Degree Field*	No. of Years Experience or Training**

*Submit 3 copies of diploma or other document verifying the degree received.
**Submit curriculum vitae. (Highlight pertinent information.)

Applicant _____

DENTAL (General Practice/Cosmetic Dentisty)

Minimum Qualifications: ***Licensure:*** Dentist (DT), State of Hawaii; and
Experience: 1-year Cosmetic Dentistry (dentures)

List at least one employee who meets minimum qualifications for general practice/cosmetic dentistry:

Name	DT License No. & Expiration Date*	No. of Years Experience**

*Submit three copies of the license(s).
**Submit curriculum vitae. (Highlight pertinent information.)

Applicant _____

NURSING

Applying for: (check all that apply)

- ☐ Advance Practice Registered Nurse (APRN)
- ☐ Registered Nurse (RN)
- ☐ Licensed Practical Nurse (LPN)
- ☐ Certified Nurses Aide (CNA)
- ■ ***APRN, Substance Abuse Assessment, Adolescent*** (see page 13)

Minimum Qualifications

Advance Practice Registered Nurse (APRN):	***Licensure:*** APRN, State of Hawaii
Registered Nurse (RN):	***Licensure:*** RN, State of Hawaii
Licensed Practical Nurse (LPN):	***Licensure:*** LPN, State of Hawaii
Certified Nurses Aide (CNA)	***Certificate:*** Certification of Good Standing, State of Hawaii

Optional: State agencies may require experience or training in family planning (FP),` pediatric nursing/healthcare (PN), behavioral health (BH), or geriatrics (G).

List at least one employee who meets minimum qualifications for each service applying:

Name	State of Hawaii License/Cert. No. & Expiration Date**	No. of Years Experience***
		FP* _____ PN* _____ BH* _____ G* _____
		FP _____ PN _____ BH _____ G _____
		FP _____ PN _____ BH _____ G _____
		FP _____ PN _____ BH _____ G _____

*FP (Family Planning); PN (Pediatric Nursing/Healthcare), BH (Behavioral Health), G (Geriatrics)

**Submit three copies of the license(s).

******* Submit curriculum vitae. (Highlight pertinent information.)

Applicant _____

NUTRITION

Applying for: (check all that apply) ☐ Dietician ☐ Nutritionist

Minimum Qualifications

Dietician: ***Registration:*** Dietician (RD), Commission on Dietetic Registration (CDR)

Nutritionist: ***Education:*** Master's degree, public health/nutritional sciences; and
Membership: American Dietetic Association (ADA)

List at least one employee who meets minimum qualifications for each service applying:

Name	RD Certification No. & Expiration Date*	ADA Membership No.**

*Submit three copies of the registration(s).
**Submit three copies of ADA membership.

Applicant _____

OCCUPATIONAL THERAPY

Minimum Qualifications: ***Registration:*** Occupational Therapist (OT), State of Hawaii

List at least one employee who meets minimum qualifications for occupational therapy:

Name	State of Hawaii OT License No. & Expiration Date*

PHYSICAL THERAPY

Minimum Qualifications: ***Licensure:*** Physical Therapist (PT), State of Hawaii

List at least one employee who meets minimum qualifications for physical therapy:

Name	State of Hawaii PT License No. & Expiration Date*

*Submit three copies of the license(s).

Applicant _____

PHYSICIAN SERVICES

Applying for: (check all that apply) ☐ General Practice ☐ Obstetrics/Gynecology ☐ Pediatrics

Minimum Qualifications

General Practice: ***Licensure:*** Physician (MD), State of Hawaii

Obstetrics/Gynecology: ***Licensure:*** Physician (MD), State of Hawaii

Pediatrics: ***Licensure:*** Physician (MD), State of Hawaii

Optional: When selecting a provider, State agencies may require board certification. (Refer to page A-1, Documentation of Minimum Requirements.)

List at least one employee who meets minimum qualifications for each service applying:

Name	State of Hawaii MD License No. & Expiration Date*	Board Name & Certification No.*	No. of Years Experience **

*Submit three copies of each credential.
**Submit curriculum vitae. (Highlight pertinent information.)

Applicant _____

PSYCHIATRY

Applying for: (check all that apply)

☐ Adult ☐ Child and Adolescent ☐ Developmental Disabilities ☐ Substance Abuse

■ ***Substance Abuse Assessment, Adolescent*** (see page 13)

Minimum Qualifications:

Licensure: Physician (MD), State of Hawaii

Experience: Adult: *1-year adult psychiatry or adult inpatient psychiatry*

Child and Adolescent : *1-year psychiatric services to adolescents and their families*

Developmental Disabilities: *1-year general psychiatric services*

Substance Abuse : 1-*year providing substance abuse assessment and treatment services for adolescents, adults, and families*

Optional: When selecting a provider, State agencies may require board certification or board eligibility. (Refer to page A-1, Documentation of Minimum Requirements.)

List at least one employee who meets minimum qualifications for each service applying:

Name	State of Hawaii MD License No. & Expiration Date**	Board Name & Certification No.**	No. of Years Experience***
			A* _____ C&A* _____ DD* _____ SA* _____
			A _____ C&A _____ DD _____ SA _____
			A _____ C&A _____ DD _____ SA _____
			A _____ C&A _____ DD _____ SA _____

*A (Adult), C&A (Child and Adolescent), DD (Developmental Disabilities), SA (Substance Abuse)

**Submit three copies of each credential.

***Submit three copies of curriculum vitae. (Highlight pertinent information.)

Applicant _____

PSYCHOLOGY

Applying for: (check all that apply)

☐ Child and Adolescent ☐ Developmental Disabilities

☐ Individual and Group Therapy ☐ Neuropsychology

☐ Psychological Testing and Evaluation ☐ Substance Abuse

■ ***Substance Abuse Assessment, Adolescent*** (see page 13)

Minimum Qualifications:

Licensure: Psychology (PSY), State of Hawaii

Experience: Individual and Group Therapy: *1-year psychological services to adolescents, families, or adult clients)*

Experience/Training: Neuropsychology: 1-*year neuropsychology services*

Optional: When selecting a provider, State agencies may require board certification or board eligibility. (Refer to page A-1, Documentation of Minimum Requirements.)

List at least one employee who meets minimum qualifications for each service applying:

Name	State of Hawaii PSY License No. & Expiration Date*	Board Name & Certification No.**	No. of Years Experience/Training***
			I&G* _____ N* _____
			I&G _____ N _____
			I&G _____ N _____
			I&G _____ N _____
			I&G _____ N _____
			I&G _____ N _____
			I&G _____ N _____
			I&G _____ N _____

*I&G (Individual and Group), N (Neuropsychology)
**Submit three copies of each credential.
***Submit three copies of curriculum vitae. (Highlight pertinent information.)

Applicant _____

SOCIAL WORK

Applying for: (check all that apply)

☐ Child and Adolescent ☐ Developmental Disabilities
■ ***Substance Abuse Assessment, Adolescent*** (see page 13)

Minimum Qualifications:

Licensure: Developmental Disabilities: Licensed Social Worker (LSW), State of Hawaii

List at least one employee who meets minimum qualifications for each service applying:

Name	State of Hawaii LSW License No. & Expiration Date*

*Submit three copies of each license.

Applicant _____

SPEECH THERAPY

Minimum Qualifications: ***Licensure:*** Speech Pathologist (SP), State of Hawaii

List at least one employee who meets minimum qualifications for speech therapy:

Name	State of Hawaii SP License No. & Expiration Date*

*Submit three copies of each license.

Applicant _____

SUBSTANCE ABUSE ASSESSMENT, ADOLESCENTS

Minimum Qualifications:

Certification: Certified Substance Abuse Counselor (CSAC): State of Hawaii, Department of Health;

or one of the following:

Licensure: Advanced Practical Registered Nurse (APRN), State of Hawaii

Psychiatrist: Physician (MD), State of Hawaii

Psychologist: Psychologist (PSY), State of Hawaii

Social Worker: Licensed Clinical Social Worker (LCSW), State of Hawaii

Experience/Training:

Psychiatrist: Accredited psychiatric residency, Accreditation Council for Graduate Medical Education (ACGME)

Advanced Practical Registered Nurse: 1-year mental health and/or substance abuse assessment and treatment services

List at least one employee who meets minimum qualifications for substance abuse assessments for adolescents:

Name	State of Hawaii License/Certification No. & Expiration Date*	Board/Certification Name and No.*

*Submit three copies of the credential(s).

Applicant _____

State of Hawaii
State Procurement Office
Honolulu, Hawaii

August 3, 2006

ADDENDUM A

TO

APPLICATION
FOR
TREATMENT PURCHASE OF SERVICES
STATEMENT OF QUALIFICATIONS 2006

The following licensures are hereby added to the minimum qualifications list for providers of Substance Abuse Assessment, Adolescent services:

Licensure: Mental Health Counselor (MHC), State of Hawaii
Marriage and Family Therapist (MFT), State of Hawaii